AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

Privacy Act of 1974 applies.

PATIENT DATA

Name (Last, First, MI)	Date of Birth (YYYYMMDD)	Patient SSN

Period of treatment (YYYYMMDD - YYYYMMDD)	Type of Treatment: ☐ Outpatient ☐ Inpatient ☐ Both

DISCLOSURE

I authorize _____
(Name of MTF/DTF) to release my patient information to:

_____
Name

_____
Address City State Zip

_____
Phone Fax

Reason for Request/Use of Medical Information:
- ☐ Personal Use
- ☐ Insurance
- ☐ Continued Medical Care
- ☐ School
- ☐ Legal
- ☐ Retirement/Separation
- ☐ Other (please specify)

Information to be Released:

Authorization Start Date (YYYYMMDD):	Authorization Expiration: ☐ Date (YYYYMMDD)_____ ☐ Action Completed

RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.

Signature of Patient/Parent/Legal Patient Representative	Relationship to Patient (if applicable)	Date (YYYYMMDD)

For Staff Use Only-(To Be Completed only Upon Receipt of Written Revocation)

☐ AUTHORIZATION REVOKED Revocation completed by _____Date ___/____/___

Imprint of Patient Identification Plate When Available	Sponsor Name: Sponsor Rank: FMP/Sponsor SSN: Branch of Service: Phone Number: